Vermont Mental Health

Questionnaire

Mental Illness – Primary Care Unit

Inpatient Unit Name _____

January, 2006

Completed By: Name: Contact (phone or email)

(LEAD)Anne Jerman, Nursing Administrator	802-241-3120 ajerman@vdh.state.vt.us

Please return this questionnaire by **----------**2006,
to Mr. Francis Pitts, architecture+ at pittsf@aplususa.com

architecture+

PURPOSE OF THIS QUESTIONNAIRE

This questionnaire has been developed by the Planning Team to assist in collecting programming and planning information for the design of a state-of-art treatment facility.

You are requested to answer the questionnaire for the areas (programs, services and facilities) for which you have responsibility. You are requested to respond to the questionnaire from the collective viewpoint, therefore all identified representatives covering each department/ service will need to meet and discuss the issues in the questionnaire to create a combined response (please see below for a description of this process). For questions or issues where there are clearly different viewpoints, we ask that you briefly outline these for us. Such differences may relate to culture, treatment philosophies/ approach, roles and responsibilities or ideal facilities/patient care environment, in moving into the future.

In all cases, we ask you to think about your new future, a future that provides for you new treatment and service environments, new technologies and the like.

The questionnaire's purpose is as follows:

- To assist the Planning Team in analyzing the current and future activities of hospital departments
- To communicate information about the Hospital's current and future programs and services to the Planning Team
- To serve as a tool for the Planning Team in evaluating demands and needs of departments
- To assist in the development of a database useful in planning activities.

INSTRUCTIONS FOR COMPLETING THIS QUESTIONNAIRE

1. Read all questions carefully before answering any part of the questionnaire.
2. Each of the designated individuals who has primary responsibility for the department/services covered should complete the questionnaire, particularly related to the existing services and facilities. We also ask that you think about the future (5 to 10 years from now)
3. Each question should be answered by entering the information requested or by entering the numerical value requested in the spaces provided. It is hoped that the questionnaire can be completed electronically. Any added information that is in electronic format should be appended to the email to which the response is returned (or a subsequent email, depending on the capacity of the email system). Any additional material that is hard copy should be scanned and emailed or faxed.
4. The sources of information should be cited if applicable (i.e. Committee Meeting Minutes or Monthly Medical Record Report).
5. Please state when information is not available or estimates are provided as answers to any questions.
6. If any question does not relate to your department, please indicate "Not Applicable".
7. It is requested that the nominated 'lead' assemble the collected response by Monday morning, January xx, 2006.
8. Please forward your completed consolidated questionnaire to Francis Pitts by --------, 2006. Forwarding it as an electronic document attached to the following email address is preferred pittsf@aplususa.com .

1. Program/Service Description:

1.1. Please provide information that summarizes the current scope of service/operations for your program/service

Department of Nursing

Responsible for 24/7 staffing of all nursing care units; supervision of staff on all units; orientation, training and education of Department of Nursing Staff. Department of Nursing Direct Care staff include RN's, LPN's, and Psychiatric Technicians.

On Nursing Care units:

staff assist patients with activities of daily living; administer medications and monitor effects; counsel and educate patients; initiate and monitor emergency involuntary procedures; provide on unit activities and therapeutic groups; interface with families; provide education, support, and crisis intervention to patients and families; participate in multidisciplinary treatment planning process; obtain meals from main kitchen and do some partial meal preparation in the unit kitchen; draw bloods and obtain other lab specs; administer EKG's; document all care provided, including constant and frequent observations of patients; transcribe orders, write and rewrite medication administration records and treatment administration records manually; fill out appropriate daily reports manually; participate in multidisciplinary treatment planning for patients; initiate and update nursing care plans electronically; nursing staff provide some housekeeping tasks such as sweeping and mopping floors, washing down patient rooms when necessary

Off units, nursing staff:

provide security to own unit as well as respond to emergencies on other units; escort patients to programming off the units; provide some of the therapeutic groups off the unit; monitor general behavior of patients with off unit privileges.

1.2. Please provide your thoughts on the changes that will occur to the nature of the program and its services in moving to a new facility (this could be an overall change to the acuity or treatment needs of the patients, new opportunities in treatment programming that will be possible in a new facility, etc.)

Expectation for improvement/enhancement of ancillary staff including security staff, housekeeping staff; lab staff; dietary staff, and therefore decrease or eliminate reliance on direct care staff for these functions.

Expectation to increase the professional nursing staff ratio

Improvement in unit milieu, with an emphasis on recovery rather than containment

Expectation that the acuity of the patients will continue to increase—more patients will be seen with complex medical/psychiatric problems; more challenging behaviors; etc.

Expectation to increase use of software programs including pharmacy software; documentation and reporting tools. With an increase in professional staff and a decrease in amount of time to transcribe, order, document, etc., will increase amount of time spent working with patients. With increase time available to work with patients, expect nursing staff to provide more therapeutic and educational groups for patients.

If a facility were created all on one level, services could be located centrally (pharmacy; dietary; programming; training and education, etc) improving efficiency, improving communication, and improving care. Having professional services (physicians, social workers,

psychologists, pharmacist) located in each patient care unit would assist with integration of services.

1.3. Please respond to the following Patient Profiles for ***both Current and Projected*** populations. The purpose of this information is to assist the planners in understanding any specific facilities requirements that would in turn assist you in caring for these individuals.

1.3.1. the approximate percent split of the patient population that is/will be ambulatory and non-ambulatory

Current: 95/5

Future: 90/10

1.3.2. percentage of the patients with physical transfer requirements and the type of transfer

Current: 95/5

Future: 90-95/5-10

1.3.3. percentage of the patients with continence problems and the nature of these

Current: 90/10

Future: 85-90/10-15

1.3.4. please provide the number or percentage of patients with the following diagnoses for your current and future patient populations:

% of patients with a primary diagnosis of:	Current	Future
Cognitive Impairment	10%	15-20%
Obsessive Compulsive Disorder	1%	1%
Neurological	10%	15%
Dual Diagnosis MH/MR	10%	10%
Dual Diagnosis (MH/Addictions)	50%	70%
Mood & Anxiety Disorders	5%	5%
Schizophrenia	45%	50%
Other mental illness related to aging	1%	10-15%
Significant co-existing medical condition	33%	45%
Others –	42%	45%

The current numbers represent the patients in the hospital this week. Many have several primary diagnoses, and therefore the numbers do not add to 100%. The "Others" category represents bipolar illness and schizoaffective illness

1.3.5. Behavioral Characteristics: please identify the percentage of your patient population with a *significant* presentation of the following characteristics currently and in the future:

% of patients with the follow-ing behavioral characteristics:	Current	Future
Aggression towards others	80%	80%
Suicide risk	25%	25%
Elopement risk	60%	75%
Sexual inappropriate behaviors	20%	25%
Pica (Ingestion of non-food products)	5%	10%
Property destruction	35%	45%

1.3.6. Patient age: please identify:

	Current	Future
Male/Female split (approximate %-age)	80%/20%	same
Age Range	18-80	18-80
Average Age	43	50

1.4. Please provide a summary of key clinical activity on-unit by the professions listed below where specific services are delivered that will influence the facility/environment considerations. The comments you provide may relate to current services that will remain valid and necessary in the future environment or services that are not/cannot currently be provided that will be necessary in the future. Please consider the response in the context of the future patient profile, changes to the mental health system as a whole and the role of the future, new hospital.

1.4.1. Psychology

N/A

1.4.2. Psychiatry

N/A

1.4.3. Social Work

N/A

2. List the main program elements (spaces or functions) of each area. This includes key features of your program. Please focus also on elements that relate to shortcomings of your area in relation to your concept of ideal patient care services and patient and staff environments.

   Patient Admissions Units:

   Patient admission assessments are completed either in the reception area of the main entrance to the hospital, or in an interview room on the admission unit. Patients are often brought in by police in shackles, and, they may be having difficulty controlling their behavior, requiring use of restraints on admission. On the Men's Admission unit is a metal detector. Having this device at the front door of the unit creates a prison like atmosphere as an introduction to the unit. In addition, on the Men's unit, the salleport entrance, in which patients and staff must be electronically admitted to the unit and electronically exit from the unit, further enhances the negative image of the unit and therefore of patient care.

   Staff work individually with patients, offer structured activities and therapeutic groups, provide meals, help patients deescalate when necessary and/or initiate emergency involuntary procedures; observe 1:1 or 2:1 and must remain at arms length; observe for medication compliance; administer medications; administer treatments; draw bloods; supervise visits; observe for adverse side effects of medications, promote trusting and therapeutic relations with patients.

   The shortcomings of the current facility include:

   Introduction to inpatient care, as stated above, that gives the impression of a prison like atmosphere.

   No private area for staff or families to meet with patients. Occasionally staff meets with patients in their rooms, but rooms only contain a bed, no chairs. Families are not allowed on the unit, so may only meet with patient in an interview room (2 on each unit) or in the dining room. Therefore, it is very difficult to have a quiet, supportive, helpful conversation.

   Patient bedrooms are small, dark, depressing, and impersonal. On Women's Admission unit, only 2 large group bathrooms, affording minimal privacy. On Men's admission Unit, one large (awful) group bathroom and several patient rooms have stainless steel sinks and toilets in them (look like corrections cells)

   Common rooms are inadequate, noisy, and sometimes not available if a group is occurring in the common room. In this case, for patients not participating in the group, they sometimes can only be in the hallway, as they are not allowed in their rooms certain times during the day.

   There are no "quiet/comfort" rooms on the units—no place for patients to be in a less stressful environment. Rooms are small, "chopped up"—reinforcing an emphasis on confinement

   Treatment rooms are small, narrow, and unpleasant.

   Furniture is uncomfortable.

   Nurses Stations on both units are forts—glassed in away from patients. On Men's admission unit, at least the common rooms can be observed from station. On Women's admission unit, a small part of the hallway can be observed. In all nurse's stationsthere is a lack of privacy to maintain confidentiality while documenting and/or discussing patient care.

   Significant lack of sinks on the unit. Increasing sinks would promote handwashing

   Medication Rooms are small, open, noisy—a "set up" for errors.

   Restraint/Seclusion rooms were recently redone with noise dampening padding. However, they remain very noisy and inadequate because of windows in the room and the antiquated ventilation system. In addition, these rooms have no bathroom connected to them. If a patient needs a toilet, they either have to get control of their behavior quickly, or, use the floor, if in seclusion. If they are in restraint, they can be offered a bedpan or urinal.

The newer, longer term care unit, is only 3 years old and looks like a nursing home. There are many bathrooms, none of them connected to the patient rooms. There are 6 double rooms and 2 singles. The doubles are problematic for recovery of patients, lack of privacy, problems with safety; problems with forced socialization, etc. The day hall is very small and is the only common area for the patients. There are no interview rooms on this unit. The only place to meet with family or meet with anyone privately is in the dining room.

Patient care areas would greatly benefit from open, flowing spaces wherever possible, to decrease the atmosphere of restraint, containment, confinement, etc.; and would promote an environment of healing and recovery. Larger spaces that could be sectioned off with dividers when necessary could be beneficial to improve efficient use of space.

Are there notable differences between what you have now and what you would like to have in the future? Why?

What was described in Architecture Plus presentation is glaringly different than what we have now. The only thing I did not mention is that the 2 admission units are too large, and the way the patient rooms are laid out, it is difficult at times to monitor the patients well. Smaller units with more living space would be a great start. Private bathrooms for patients would be great

Social worker and physician offices on the units would improve communication and efficiency and would improve access to patients and families. Currently these offices are away from the patient care areas which creates significant barriers to care and team function (we/they culture)

Staff need a lounge with adequate space to store their belongings safely. Staff need male and female bathrooms

Please describe the internal operations and functions of each area. Please discuss any problems or problem areas that affect the smooth functioning of each area. An example of this would be work areas that are located in several places across the Facility fragmenting workflow, supervision, etc. Please specifically address the following issues:

Internal operations:

Programming for patients is located in several areas in the building. Whenever patients attend programming off the unit, it involves staff members taking patients off the unit and staying with them. This decreases staff on the unit, leaving less staff with patients who are less predictable and having more difficulty managing their behavior.

Treatment rooms are very small and narrow. With door closed, it can be difficult to hear if someone needs help. It can be easy for patients to reach/obtain dangerous objects. This necessitates having more staff in a small space to maintain safety. More people in small area increases anxiety. A vicious cycle.

Medication areas are small and noisy. Sound can be amplified, making it difficult to hear patients. They come up to a window to ask for medications, and must ask loudly, compromising their privacy.

Meals are prepared at the other end of the state complex. Nursing staff must go to the kitchen to obtain meals, and then return the trays to the kitchen after the meal. Meals can cool considerable just getting them to the unit.

Are there notable differences between what you have now and what you would like to have in the future? Why?

Larger, more comfortable living area. Fewer obstacles between staff and patients such as a medication window.

A main kitchen closer to the unit, or, dietary staff to help out.

Private bathrooms for patients

Reading areas or librarys on the units.

Softer lighting, decreased noise—both promote environment of healing.

Smaller, patient room areas (houses) to decrease sense of crowdedness, improve ability to admit to mens/womens units—improve ability to socialize in common areas while keeping bedroom areas smaller, safer

Please specifically address the following issues:

Work Flow Functional Characteristics:	Comments
Medication Administration	All manual—transcribing orders, writing medication administration records. Cart is taken to pharmacy by nursing staff and pharmacist fills each drawer. On the unit, patients must come to the window, or, staff "pour" the medication then take it out to the patient.
Food Preparation	Meals prepared in main kitchen, but brought to units by nursing staff. Some food prep also done in the kitchens on each nursing unit.
Meal Service /Dining Style (e.g. trays, bulk, family style?)	Individual trays in a dining room on each unit. Patients are not allowed to eat in their rooms. If there is a problem, they may be "assigned" to eat alone in an interview room. Dining tables are very small.

Level of Supervision required on unit	Minimum check for each patient is every 30 minutes. For an average census of 50 patients, there are usually an average of 8 1:1 observations throughout the hospital.
Level of Supervision off unit	Patients may be off the unit is supervised groups of 5 (2 techs with 5 patients) Or, supervised 1:1. Occasionally some patients have hospital and grounds privileges, but very infrequently.

3. Please comment on the following Program Policy Considerations:

Program Policy Consideration:	**Comment:**
Off/On Patient Care Unit (PCU) living area Recreation/Leisure time Activities	
Consumer/Patient space access/restriction.	
• Kitchen	All patients restricted from the kitchen except in OT area.
• Dining Area	Used for meals, structured activities, therapeutic activities; staff meetings, treatment planning meetings, daily rounds and shift report meetings. Locked with not in use.
• Exit doors	Locked
• Bathrooms	Large group bathrooms on admissions units, several bathrooms on smaller longer term care unit
• Bedrooms	Singles on admissions units, doubles in basement unit. Patients are restricted from their rooms during programming.
• Leisure space	Day Halls on units. TV's off during programming hours
Time out/seclusion room policy	Patients can take voluntary time out in room. If involuntary, always in R/S room
Clinical treatment/office space on/off unit	Crowded, marginal.
Day Services on/off PCU	OT area in a different building. Not many patients have privileges allowing them to go off the unit to the larger space. There is an activity area in the basement that is small. Patients are split into small groups and can spend approximately one hour per day in this area.
Visual/Auditory observation requirements	Many patients on 1:1 observation or 15 minute observation. Minimum obs. Q30 minutes.
School age Education, On/Off PCU unit	
Requirements for Community Living Skills Training On/Off unit	
• Mock Apartment	N/A
• Kitchen	Off unit
• Dish washing	N/A
• Dining	Dining hall on each unit
• Home-like bathroom	Only on longer term care unit
• Other?	
Vocational Training	none
• In-House	
• In-Community	
Visitation (on-unit/off-unit; restrictions/need for supervision, etc.)	Unless patient has hospital/grounds privileges, all visits occur on the unit, and only in the interview room or in the dining room. If patient is on constant observation, staff member keeps patient within site, but stands outside the room.

4. Please indicate if there are any operational changes that would improve the efficiency of each area, in particular any physical features that could make your area more efficient.

   More programming areas that do not involve taking patients off the unit would decrease need to have staff leave the unit as frequently.

   Computerized medication administration system

   Please note any differing opinions that still exist at the conclusion of your discussions:

5. Please describe any other anticipated changes that may occur within the next five years that might have a significant impact on each area's operation, where these have not been covered in earlier questions. *These changes are most likely to be the result of external or industry changes.*

   Some items that you might discuss here are: planning issues/trends, new services, new methods of delivering care/services, personnel, equipment, adjustments to operating costs, method of operation, etc. This includes important executive directives or licensing objectives that may impact space requirements or influence locations or adjacencies.

   Please note any differing opinions that still exist at the conclusion of your discussions:

6. Please list the titles of ***current*** staff and number of FTE's and Bodies in each area and note if an office or workstation is needed. An office would be required if confidential conversations take place in the course of daily work. For offices that will also host others from outside the area (other staff, multiple clients or visitors/family members) please indicate the "usual" number of such others – this will enable us to appropriately size the offices for the most common situations. Are any of the staff transients? Are there individuals that may only be in the area for short periods of time and only occasionally – ie hoteling areas (access to a workstation for short periods of time in the day) for some staff or outside organizations?

Staff Title	FTE's	Bodies	Office / Workstn	Usual # Visitors to office / wrkstn	Requires Dedicated or Multi-Use	Hoteling Areas
Nurse Manager	1	1	Brooks 1	1-3/visit	dedicated	
Nurse Manager	1	1	Brooks 2	1-3/visit	dedicated	
Nurse Manager	1	1	Brooks 3	1-3/visit	dedicated	
Nursing Service Manager	1	1			Dedicated—unclear if this would be necessary—could be nurse manager and other 3 are assistant managers located on the units	

Staff Title	FTE's	Bodies	Office / Workstn	Usual # Visitors to office / wrkstn	Requires Dedicated or Multi-Use	Hoteling Areas

7. Adjacency Requirements

7.1. Describe ***ideal critical internal adjacency relationships*** within your area(s), regardless of whether these are currently achieved or not possible. These relationships may be a result of patient flow, material flows, or staff movements or supervision needs

Between (function / area)	And (function / area)	Reason
Pharmacy	Patient care unit	Efficiency
Physicians offices	Patient care unit	Efficiency, improve communication, access, responsiveness, improve sense of team
Social worker offices	Patient care unit	Efficiency, improve communication, access, responsiveness, improve sense of team
Staff lounge	Patient care unit	Morale, staff self care
Programming areas	Patient care unit	Improve access, communication, efficient use of staff

Please note any differing opinions that still exist at the conclusion of your discussions:

8. Adjacency Requirements (cont)

7.2. Describe critical ***ideal future external adjacency relationships*** that each area has with other departments in the facility. These relationships may be a result of patient flow, materials flow, or staff movements

Using the "Closeness" indicator identified below, indicate how near you should be located to the listed departments. Identify the most important "Reason" from the list below, or add explanation. Also, estimate the number of contacts you make per day with that particular department. *Again, please think about it from your understanding of the future patient profile and a new facility/environment.*

CLOSENESS INDICATOR	REASON INDICATOR
1 - Directly next to	A - Patient movement
2 - Same floor	B - Staff movement
3 - Doesn't matter	C - Materials movement

Department	Closeness	Reason	Contacts/Day

Please note any differing opinions that still exist at the conclusion of your discussions:

8. Please list materials, space, personnel or other resources that you share with any other department(s). Please indicate which department(s) and describe the nature of the sharing.

What do you Share	Share with Whom	Nature of Sharing
One office on womens admission units—8x10 No office on mens admission unit	All RN's, MD's, Nurse Manager, social workers	Interviews, use of computer, phone calls for patients, supervision with staff
One office on longer term care unit	All RN's	Staff supervision

There is no lounge area for staff either on or off the unit—no area for rest, get away from noise, debrief quietly.

10. Please comment on the need (if appropriate) for the following Assistive Technology – Adaptive Equipment. Do you anticipate this to change, and if so, please briefly describe the nature of the change.

Assistive Technology-Adaptive Equipment	**Need (e.g. high / moderate / low / no need):**
Physical Transfer Equipment (Hoyer lifts etc)	low
Respiration Equipment	low
Oxygen	low
Tube feeding equipment	No need
Special needs ambulation/transport (Electronic Scooters/mechanical tricycles etc.)	low
Communication Equipment	high
Specialized Bathing Equipment (Hoyer lifts etc.)	low
Other (please specify)	

11. Is there any other information or data that you feel the planning team should be aware of that has not been requested by this questionnaire?

SUPPLEMENTAL QUESTIONS

We understand that the primary care unit will be part of an acute care medical hospital. The following questions will provide the planning team with information about how adjunct services will be integrated into the operation of the primary care unit and the extent to which those services will be provided by the medical hospital.

Patient Therapy / Activity

1. Will there be off-unit recreational, vocational or socialization activities and, if so, what will they be?

2. Can they be located adjacent to the unit?

3. How much space will be needed for these functions?

4. Can religious services or spiritual counseling be conducted on or near the unit?

Clinical Ancillaries

1. Where will exams be done upon admission?

2. Where will routine medical clinic and follow-up exams be done?

3. Where will emergency services be provided and how will patients be transported?

4. Where will lab and x-ray work be done?

5. Will a specialized pharmacy be needed or do you expect to be integrated into the medical hospital pharmacy? If the pharmacy is integrated will additional space be needed?

6. Admissions
    a. How will patients be brought to the hospital?

    b. Where will they be received?

c. How many patients do you expect to have to accommodate in the admissions area at one time?

d. Will admissions be scheduled or will they occur throughout the day?

e. When are the peak times for admissions?

f. Who will process admissions and where will they take place? (e.g. existing medical emergency room, new space adjacent to the medical emergency room, new or existing space remote from the emergency room).

g. Please describe the admissions process in terms of time and patient/staff flow.

h. Who will transport the patients from the admitting are to the unit?

i. Will there be dedicated admissions staff. If so, where will they be located?

j. What is the expected range of behavior of patients, and in what proportion, upon admission? (e.g. violent, highly agitated, suicidal, under the influence of alcohol or drugs, docile etc.)

Dietary

1. What form of meal service do you anticipate?

Administrative Services

1. How many administrative personnel will there be? Will they include business office and personnel functions?

2. Who are they and where will they be located? (Please list by department or function).

3. Will they be integrated with the medical hospital?

4. Are there State regulations that would prohibit integration of these services?

5. If they are to be integrated, can they be absorbed into existing space in the medical hospital?

6. Patient legal services are likely to be required. How much space will be needed and where should it be located?

Information Technology

1. Which of the following functions will be integrated with the medical hospital?
    a. Information Services (data processing)

    b. Medical Records

    c. Quality Assurance/Risk Management/Utilization Review

    d. Staff Development

    e. Communications

    f. Education and conferencing

2. Are there any State regulations that would prohibit integration of these services?

3. Will additional space be required for the services to be integrated or can they be absorbed into existing space?

4. How much space will be needed for functions that will not be integrated and where will they be located? (Please list by function)

Facilities Management

1. Which of the following functions will be integrated with the medical hospital?

    a. Environmental Services

    b. Laundry and Linen

    c. Maintenance

    d. Materials Management and Central Medical Supply

    e. Security and Fire Safety

    f. Transportation

2. Are there State regulations that would prohibit integration of these services?

3. Will additional space be required for the services to be integrated or can they be absorbed into existing space? (Please list by function)

4. How much space will be needed for functions that will not be integrated and where will they be located? (Please list by function).

5. Will there be special security personnel and arrangements for the psychiatric service that will differ from the medical hospital?

Outreach

1. Will there be dedicated staff for outreach and patient follow up services on-site?

Family Support and Visitation

1. Will there be on-site facilities for family and visitors such as a residential suite? How much space will be required? (Please list by function).